ADULT HISTORY
IHA PRIMARY CARE

Please complete this form and bring it with you to your visit.

PLEASE BRING ALL MEDICATION(S) TO YOUR APPOINTMENT.

Date: ______________________

Name: ____ Date of Birth: ______________

(Last) (First) (Middle)

☐ Male ☐ Female ☐ Other ☐ Single ☐ Married ☐ Widow(er) ☐ Partner ☐ Divorced

Who do you live with? ☐ Alone ☐ Partner ☐ Family ☐ Other Occupation: ______________________

Emergency Contact Name: ______________________ Emergency Contact Phone: ______________________

☐ **Routine Check Up — No Symptoms**

Reason for Visit: *(please list all current symptoms)*

1. ______________________
2. ______________________
3. ______________________

Chronic Problems:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Allergies:

Source	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

Do you take your medications as directed? ☐ Yes ☐ No

Please bring all medications to your visit in a bag.

Name of Medication	Dosage	Times Per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Supplements / Herbs / Over the counter medication:

1. ______________________
2. ______________________

FOR WOMEN ONLY

How many: Pregnancies __________ Live births __________

Menstrual History:

Age when menstrual period began __________

Do you use any form of birth control? ☐ Yes ☐ No

If yes, what? ______________________

First day of last menstrual period ______________________

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Have you ever had any of the following? *(If yes, enter date to those that apply)*

TEST	Date
Eye Exam	________
Dental Exam	________
Cholesterol	________
PPD (TB test)	________
HIV test	________
Hepatitis C	________
Stool blood test	________
Colonoscopy	________
Bone density	________
Chest X-Ray	________
Heart Stress Test	________
Blood transfusion	________
MRI	________
Sleep Study	________
Other	________

Surgical History	Date	Surgical History	Date
Angioplasty	________	Heart Valve	________
Appendectomy	________	Hernia repair	________
Arthroscopy of knee	________	Hip/Knee replacement	________
Back surgery	________	Hysterectomy	________
CABG (Heart bypass)	________	LASIK	________
Carpal tunnel release	________	Mastectomy	________
Cataract extraction	________	Small bowel resection	________
Colon resection	________	Thyroidectomy	________
Colostomy	________	Tonsillectomy	________
Defibrillator	________	Pacemaker	________
Fracture	________	Prostate surgery	________
Location: ________	________	Other	________
Gallbladder out	________		
Gastric bypass	________		
Gastric Band	________		
Gastric Sleeve	________		

Other recent physician or hospital visits:

1. ______________________________ **2.** ______________________________ **3.** ______________________________

Social History *(Check all that apply)*

Alcohol Use ☐ Yes ☐ No ☐ Former

Years Drinking ________

Drinks per week ________

Type ________

Quit date ________

Last drink ________

Caffeine ☐ Yes ☐ No Amount/week

Coffee ________

Pop/Soda ________

Energy drinks ________

Other: ________

Exercise ☐ Yes ☐ No

Frequency (Hours/week): ________

Types:

Tobacco ☐ Yes ☐ No ☐ Former

☐ Cigarettes

Packs per day ________

☐ Cigars

☐ Chewing Tobacco

☐ Would like to quit

Years of use ________

Year quit ________

Sexual History

Are you currently sexually active?

☐ Yes ☐ No

Any history of sexually transmitted diseases?

☐ Yes ☐ No

If yes, when?

Recreational drug use

☐ Yes ☐ No ☐ Former

Have you ever used IV drugs?

☐ Yes ☐ No

Personal safety

Do you wear your seatbelt?

☐ Yes ☐ No

Do you have difficulty dressing yourself?

☐ Yes ☐ No

Do you have difficulty carrying 10 pounds?

☐ Yes ☐ No

Do you have difficulty shopping?

☐ Yes ☐ No

Other

Have you experienced a fall in the last year? ☐ Yes ☐ No If yes, how many times have you fallen this year?____________

Were you injured in the fall(s)? ☐ Yes ☐ No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly daily

Feeling down, depressed or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly daily

Do you work? ☐ Yes ☐ No ☐ Retired

Do you have a Living Will/Durable Power of Attorney? ☐ Yes ☐ No

How many children do you have? ________

Personal and Family History

☐ Unknown/Adopted

(Check all that apply)

Circle any items that were known cause of death for relative

MEDICAL CONDITION	SELF	RELATIVE
ADD/ADHD	☐ Yes ☐ No	________
Alcoholism	☐ Yes ☐ No	________
Allergies	☐ Yes ☐ No	________
Alzheimer's Disease/Dementia	☐ Yes ☐ No	________
Anemia	☐ Yes ☐ No	________
Angina	☐ Yes ☐ No	________
Anxiety	☐ Yes ☐ No	________
Arthritis	☐ Yes ☐ No	________
Asthma	☐ Yes ☐ No	________
Atrial fibrillation	☐ Yes ☐ No	________
BPH (enlarged prostate)	☐ Yes ☐ No	________
Blood clots	☐ Yes ☐ No	________
Blood disease (vists to hematology)	☐ Yes ☐ No	________
Cancer(s):		
Breast	☐ Yes ☐ No	________
Colon	☐ Yes ☐ No	________
Lung	☐ Yes ☐ No	________
Prostate	☐ Yes ☐ No	________
Other:	☐ Yes ☐ No	________
CVA (Stroke or TIA)	☐ Yes ☐ No	________
Colon problems	☐ Yes ☐ No	________
COPD (emphysema)	☐ Yes ☐ No	________
Coronary artery disease	☐ Yes ☐ No	________
Depression	☐ Yes ☐ No	________
Developmental Delay	☐ Yes ☐ No	________
Diabetes	☐ Yes ☐ No	________
Eczema	☐ Yes ☐ No	________
Gall Stones	☐ Yes ☐ No	________
Gallbladder disease	☐ Yes ☐ No	________
GERD	☐ Yes ☐ No	________
Glaucoma/Cataracts	☐ Yes ☐ No	________
Hearing deficiency	☐ Yes ☐ No	________
Heart disease/problems	☐ Yes ☐ No	________
before age 40 (male)	☐ Yes ☐ No	________
before age 50 (female)	☐ Yes ☐ No	________
Hemorrhoids	☐ Yes ☐ No	________
Hernia	☐ Yes ☐ No	________
Hepatitis C	☐ Yes ☐ No	________
Hyperlipidemia (high cholesterol)	☐ Yes ☐ No	________
Hypertension (high blood pressure)	☐ Yes ☐ No	________
Injuries:		
Concussion or head injury	☐ Yes ☐ No	________
Car/motorcycle accident injury	☐ Yes ☐ No	________
Ever been knocked unconscious	☐ Yes ☐ No	________
Broken bones?	☐ Yes ☐ No	________
Which ones?		
Any other injuries:	☐ Yes ☐ No	________

MEDICAL CONDITION	SELF	RELATIVE
Irritable bowel disease	☐ Yes ☐ No	________
Kidney disease	☐ Yes ☐ No	________
Kidney stones	☐ Yes ☐ No	________
Learning disability	☐ Yes ☐ No	________
Liver disease	☐ Yes ☐ No	________
Lupus	☐ Yes ☐ No	________
Mental illness	☐ Yes ☐ No	________
Migraines/headaches	☐ Yes ☐ No	________
Obesity	☐ Yes ☐ No	________
Osteoarthritis	☐ Yes ☐ No	________
Osteoporosis	☐ Yes ☐ No	________
Peptic ulcer disease	☐ Yes ☐ No	________
Peripheral vascular disease	☐ Yes ☐ No	________
Psoriasis	☐ Yes ☐ No	________
Rheumatoid Arthritis	☐ Yes ☐ No	________
Seizure disorder/Epilepsy	☐ Yes ☐ No	________
Thyroid disease	☐ Yes ☐ No	________
OTHER (please list)		
________________	☐ Yes ☐ No	________
________________	☐ Yes ☐ No	________
________________	☐ Yes ☐ No	________

Have you had the following illnesses or vaccines?

Check all that apply	Date
☐ Hepatitis A	________
☐ Hepatitis B	________
☐ HPV (Gardasil)	________
☐ Influenza	________
☐ Last tetanus vaccination	________
☐ Pneumonia (Pneumovax)	________
☐ Pneumonia (Prevnar)	________
☐ Shingles shot (Zostavax)	________

FOR WOMEN ONLY

Screening Tests	**Date**
Last pap smear:	________

Any abnormal pap smears?

☐ Yes ☐ No If yes, indicate results and date.

Mammogram: ________

Any abnormal mammograms?

☐ Yes ☐ No If yes, indicate results and date.